



REFORMING VIRGINIA’S MENTAL HEALTH SYSTEM

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Our country has recently experienced tragic events that have shaken our sense of security. Whether it is a classroom of college students in Blacksburg, a senior citizen walking her dog in broad daylight on a Richmond street, or a bustling department store in Omaha, these violent acts are forcing some important questions about mentally ill individuals.

“Why can’t we figure out who is at risk of committing these violent acts and prevent them from happening?” “Are people with mental illness more dangerous than the general population?” “Why does it seem like so many of these violent acts are committed by individuals with mental illness?”

These questions have been surrounded by much misinformation and it is important to attempt to answer them correctly.

First, there is no perfect predictor of someone’s risk for violence. However, recent research allows mental health clinicians to move away from predicting if someone is “dangerous” with a simple yes or no answer to more accurately categorizing individuals into high, average, and low risk of violent behavior. Still, these risks assessments, like predicting weather, are most accurate over a short timeframe of days to weeks after assessment than a longer term of months to years. Overall, we have done a better job researching actuarial factors that contribute to risk of violence.

Second, we now can better answer whether the mentally ill are more dangerous than the general public. For example, a McArthur Foundation-funded research project found the risk of violence is the same for individuals released from psychiatric hospitals and the general population as long as they are not abusing substances. The risk of violence increases for anyone using street drugs or alcohol; but, that risk increases more among the mentally ill.

Third, most violence is not committed by those with mental illness. The risk for violence in our society attributed to mental illness is about three to five percent. The number of people with mental illness who will commit a significantly violent act is still a small percentage of those even in the high risk categories. Additionally, individuals with mental illness are much more likely to be victims of violence than perpetrators.

What then can we do to lessen the likelihood that even that very small subset of individuals with mental illness will commit a violent act? The answer challenges all mental health systems. Even if we had enough locked psychiatric beds to confine all high risk mentally ill individuals, the civil liberties that would have to be trampled to confine those who will never be violent would not be tolerable in our society. That does not mean that we throw up our hands in defeat.

We can:

1. Continue to train clinicians to use state-of-the-art practices, including risk assessments, to identify as best we can that small percentage of the mentally ill who are at higher risk of violence. Code language can be changed to better define who is at highest risk and who may need a court order and/or resources to assist with adherence to treatment.

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2. Ensure that emergency and crisis interventions, outpatient visits, and case management services are available to allow mental health clinicians to not only treat and monitor the factors attributable to violence risk, but also enhance community services that would prevent individuals from moving into high risk categories.
3. Train clinicians and others involved in emergency treatment for individuals at risk of violence to communicate critical information with each other, including otherwise private health information, in the service of providing treatment.

Virginia has the expertise and the will to tackle these issues. For years, the mental health system and its many partners have been calling for change and working together to transform a fragmented and under-resourced service system.

Governor Kaine has made reform of the mental health system a priority in his budget. Informed by his panel investigating the Virginia Tech incident, he will be supporting legislation that addresses the three issues outlined above. In addition, the Commission on Mental Health Law Reform has been working for over a year on critical issues related to civil commitment and access to services. The General Assembly has had productive meetings and studies recently and has stated interest in continuing to invest in more community mental health resources.

We can accurately predict that the risk of not acting now to invest in and reform our mental health system will also be a tragedy.

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Available to citizens statewide, Virginia's public mental health, mental retardation and substance abuse services system is comprised of 40 community services boards (CSBs) and 16 state facilities. DMHMRAS seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals with mental health, mental retardation or substance abuse disorders.